FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032029

Facility Name: HICKORY NURSING PAVILION, INC.

Address: 9246 SOUTH ROBERTS ROAD (Number) HICKORY HILLS (City) 60457 (Zip Code)

County: COOK

Telephone Number: (708) 598-4040 **Fax #** (708) 598-3796

IDPA ID Number: 36-3499382001

Date of Initial License for Current Owners: 3/1/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) HOWARD WENGROW

(Title) OWNER

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) RICHARD S. SGARLATA

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	34	Skilled (SNF)	34	12,444	1
2		Skilled Pediatric (SNF/PED)			2
3	40	Intermediate (ICF)	40	14,640	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,084	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,074	556	1,177	7,807	8
9	SNF/PED					9
10	ICF	12,200	1,330		13,530	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,274	1,886	1,177	21,337	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.78%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/1/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 1,177

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	99,747	16,191	5,109	121,047		121,047		121,047			1
2	Food Purchase		97,089		97,089	(21,653)	75,436	(85)	75,352			2
3	Housekeeping	47,135	24,624		71,759		71,759		71,759			3
4	Laundry	35,424	8,780		44,204		44,204		44,204			4
5	Heat and Other Utilities			40,403	40,403		40,403	980	41,383			5
6	Maintenance	24,282	9,223	52,290	85,795		85,795	(2,394)	83,401			6
7	Other (specify):*							1,058	1,058			7
8	**TOTAL General Services**	206,588	155,907	97,802	460,297	(21,653)	438,644	(441)	438,204			8
	B. Health Care and Programs											
9	Medical Director			1,800	1,800		1,800		1,800			9
10	Nursing and Medical Records	663,325	15,401	4,992	683,718		683,718	(437)	683,281			10
10a	Therapy	34,185		11,238	45,423		45,423		45,423			10a
11	Activities	28,161	1,167	1,680	31,008		31,008		31,008			11
12	Social Services	27,810		1,818	29,628		29,628		29,628			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	753,481	16,568	21,528	791,577		791,577	(437)	791,140			16
	C. General Administration											
17	Administrative	57,661		145,200	202,861		202,861	(33,562)	169,299			17
18	Directors Fees											18
19	Professional Services			30,376	30,376	(2,160)	28,216	3,103	31,319			19
20	Dues, Fees, Subscriptions & Promotions			21,813	21,813		21,813	(10,466)	11,347			20
21	Clerical & General Office Expenses	9,468	36,731	48,108	94,307		94,307	(14,872)	79,435			21
22	Employee Benefits & Payroll Taxes			144,365	144,365	21,653	166,018		166,018			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,425	1,425		1,425	202	1,627			24
25	Other Admin. Staff Transportation			384	384		384	992	1,376			25
26	Insurance-Prop.Liab.Malpractice			22,245	22,245		22,245	951	23,196			26
27	Other (specify):*							7,838	7,838			27
28	**TOTAL General Administration**	67,129	36,731	413,916	517,776	19,493	537,269	(45,814)	491,455			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,027,198	209,206	533,246	1,769,650	(2,160)	1,767,490	(46,692)	1,720,798			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

HICKORY NURSING PAVILION, INC.
0032029
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	21,653	
2	FOOD		21,653

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	2,160	
19	PROFESSIONAL FEES		2,160

To reclass cost of appealing real estate taxes

Facility Name & ID Number HICKORY NURSING PAVILION, INC. #0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			22,966	22,966		22,966	71,243	94,209			30
31	Amortization of Pre-Op. & Org.							1,275	1,275			31
32	Interest			1,186	1,186		1,186	68,827	70,013			32
33	Real Estate Taxes			93,401	93,401	2,160	95,561		95,561			33
34	Rent-Facility & Grounds			180,000	180,000		180,000	(174,832)	5,168			34
35	Rent-Equipment & Vehicles							2,423	2,423			35
36	Other (specify):*											36
37	**TOTAL Ownership**			297,553	297,553	2,160	299,713	(31,064)	268,649			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,134	65,372	108,506		108,506		108,506			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,626	40,626		40,626		40,626			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		43,134	105,998	149,132		149,132		149,132			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,027,198	252,340	936,797	2,216,335		2,216,335	(77,756)	2,138,579			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	34,491	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(85)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,640)	20		18
19	Entertainment				19
20	Contributions	(300)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(28,633)	21		24
25	Fund Raising, Advertising and Promotional	(962)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,571)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,603)	20		28
29	Other-Attach Schedule	(14,249)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (22,552)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(55,204)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (55,204)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (77,756)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

HICKORY NURSING PAVILION, INC.

ID# 0032029

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Interest Expense	(6,547)	32	2
3	Capitalized Repair/Maintenance	(8,047)	6	3
4	Architect Work Not Accrued	2,393	19	4
5	LLC Fees	(200)	21	5
6	Legal Fees	(457)	19	6
7	Illinois Replacement Taxes	(1,250)	21	7
8	Illinois Council Dues	(141)	20	8
9				9
10				10
11				11
12				12
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83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(14,249)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(85)											(85)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			980									980	5
6	Maintenance	(8,047)		391	5,262								(2,394)	6
7	Other (specify):*				1,058								1,058	7
8	**TOTAL General Services**	(8,132)		1,371	6,320								(441)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(437)									(437)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**			(437)									(437)	16
	C. General Administration													
17	Administrative			9,981	(43,543)								(33,562)	17
18	Directors Fees													18
19	Professional Services	1,936	457	710									3,103	19
20	Fees, Subscriptions & Promotions	(10,646)		180									(10,466)	20
21	Clerical & General Office Expenses	(33,654)	2,325	16,457									(14,872)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			202									202	24
25	Other Admin. Staff Transportation			992									992	25
26	Insurance-Prop.Liab.Malpractice			951									951	26
27	Other (specify):*			2,954	4,884								7,838	27
28	**TOTAL General Administration**	(42,364)	2,782	32,427	(38,659)								(45,814)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(50,496)	2,782	33,361	(32,339)								(46,692)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	34,491	35,397	1,355									71,243	30
31	Amortization of Pre-Op. & Org.		1,275										1,275	31
32	Interest	(6,547)	75,374										68,827	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(180,000)	5,168									(174,832)	34
35	Rent-Equipment & Vehicles			2,423									2,423	35
36	Other (specify):*													36
37	**TOTAL Ownership**	27,944	(67,954)	8,946									(31,064)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(22,552)	(65,172)	42,307	(32,339)								(77,756)	45

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				HICKORY HEALTH CARE ASSOCIATES		BLDG. PTSHP.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 180,000	HICKORY HEALTH CARE ASSOC.		$	$ (180,000)	1
2	V	32	INTEREST INCOME	824	HICKORY HEALTH CARE ASSOC.			(824)	2
3	V	21	ACCOUNTING FEES		HICKORY HEALTH CARE ASSOC.		785	785	3
4	V	21	BANK CHARGES		HICKORY HEALTH CARE ASSOC.		90	90	4
5	V	32	MORTGAGE INTEREST		HICKORY HEALTH CARE ASSOC.		76,198	76,198	5
6	V	30	DEPRECIATION		HICKORY HEALTH CARE ASSOC.		35,397	35,397	6
7	V	31	AMORTIZATION		HICKORY HEALTH CARE ASSOC.		1,275	1,275	7
8	V	21	LLC FEES		HICKORY HEALTH CARE ASSOC.		200	200	8
9	V	19	LEGAL FEES		HICKORY HEALTH CARE ASSOC.		457	457	9
10	V	21	ILL RT		HICKORY HEALTH CARE ASSOC.		1,250	1,250	10
11	V								11
12	V								12
13	V								13
14	Total			$ 180,824			$ 115,652	$ * (65,172)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	STAY CARE MANAGEMENT, LTD.	100.00%	$ 980	$ 980	15
16	V	6	REPAIRS AND MAINT.		STAY CARE MANAGEMENT, LTD.	100.00%	391	391	16
17	V	10	REHABILITATION CONS.		STAY CARE MANAGEMENT, LTD.	100.00%	(437)	(437)	17
18	V	17	ADMIN. SAL.-NON OWNER		STAY CARE MANAGEMENT, LTD.	100.00%	9,981	9,981	18
19	V	19	PROFESSIONAL FEES		STAY CARE MANAGEMENT, LTD.	100.00%	710	710	19
20	V	20	DUES, SUBSCRIPTIONS		STAY CARE MANAGEMENT, LTD.	100.00%	180	180	20
21	V	21	CLERICAL & GENERAL		STAY CARE MANAGEMENT, LTD.	100.00%	16,457	16,457	21
22	V	24	SEMINARS		STAY CARE MANAGEMENT, LTD.	100.00%	202	202	22
23	V	25	ADMIN. STAFF TRAVEL		STAY CARE MANAGEMENT, LTD.	100.00%	992	992	23
24	V	26	INSURANCE		STAY CARE MANAGEMENT, LTD.	100.00%	951	951	24
25	V	27	EMPLOYEE BENEFITS		STAY CARE MANAGEMENT, LTD.	100.00%	2,954	2,954	25
26	V	30	DEPRECIATION		STAY CARE MANAGEMENT, LTD.	100.00%	1,355	1,355	26
27	V	34	BUILDING RENT		STAY CARE MANAGEMENT, LTD.	100.00%	5,168	5,168	27
28	V	35	EQUIPMENT RENTAL		STAY CARE MANAGEMENT, LTD.	100.00%	2,423	2,423	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 42,307	$ * 42,307	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIET. COMP - S. WEBSTER	$	STAY CARE MANAGEMENT, LTD.	100.00%	$	$	15
16	V	6	MAINT. COMP. - NON-OWNER		STAY CARE MANAGEMENT, LTD.	100.00%	5,262	5,262	16
17	V	7	EMP. BEN. - S. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%			17
18	V	7	EMP. BEN. - MAINT. NON-OWNER		STAY CARE MANAGEMENT, LTD.	100.00%	1,058	1,058	18
19	V	17	ADMIN. BONUS		STAY CARE MANAGEMENT, LTD.	100.00%			19
20	V	17	ADMIN. COMP - H. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	85,418	85,418	20
21	V	17	ADMIN. COMP - J. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	16,239	16,239	21
22	V	27	EMP. BEN. - H. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	4,081	4,081	22
23	V	27	EMP. BEN. - J. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	803	803	23
24	V	17	MANAGEMENT FEES	145,200	STAY CARE MANAGEMENT, LTD.	100.00%		(145,200)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 145,200			$ 112,861	$ * (32,339)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JEFF WEBSTER	OWNER	ADMIN	14.19	SEE ATTACHED	4	6.15	SALARY	$ 16,239	17-7	1
2	HOWARD WENGROW	OWNER	ADMIN	14.19	SEE ATTACHED	20	30.77	SALARY	85,418	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 101,657		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Staycare Management, Ltd.
Street Address: 7313 N. Western Ave.
City / State / Zip Code: Chicago, IL 60645
Phone Number: (773) 338-2121
Fax Number: (773) 338-2286

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	177,354	5	$ 8,146	$	21,337	$ 980	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	177,354	5	3,250		21,337	391	2
3	10	REHABILITATION CONS.	PATIENT DAYS	177,354	5	(3,636)		21,337	(437)	3
4	17	ADMIN. SAL.-NON OWNER	PATIENT DAYS	177,354	5	82,960	82,960	21,337	9,981	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	177,354	5	5,905		21,337	710	5
6	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	177,354	5	1,497		21,337	180	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	177,354	5	136,787	96,823	21,337	16,457	7
8	24	SEMINARS	PATIENT DAYS	177,354	5	1,675		21,337	202	8
9	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	177,354	5	8,245		21,337	992	9
10	26	INSURANCE	PATIENT DAYS	177,354	5	7,905		21,337	951	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	177,354	5	24,552		21,337	2,954	11
12	30	DEPRECIATION	PATIENT DAYS	177,354	5	11,266		21,337	1,355	12
13	34	BUILDING RENT	PATIENT DAYS	177,354	5	42,960		21,337	5,168	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	177,354	5	20,136		21,337	2,423	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 351,648	$ 179,783		$ 42,307	25

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Staycare Management, Ltd.
Street Address: 7313 N. Western Ave.
City / State / Zip Code: Chicago, IL 60645
Phone Number: (773) 338-2121
Fax Number: (773) 338-2286

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	35	1	19,277	19,277			1
2	6	MAINT. COMP. - NON-OWNER	AVG. HOURS WORKED	40	5	26,310	26,310	8	5,262	2
3	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	35	1	1,603				3
4	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	5	5,291		8	1,058	4
5	17	ADMIN. BONUS	AVG. HOURS WORKED	40	1	250				5
6	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	5	277,610	277,610	20	85,418	6
7	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	65	5	263,887	263,887	4	16,239	7
8	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	5	13,264		20	4,081	8
9	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	65	5	13,052		4	803	9
10	30	DEPR.- AUTO - MINI VAN	AVG. HOURS WORKED	35	1	1,775				10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 622,319	$ 587,084		$ 112,861	25

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Hickory Health Care Assoc	X		Mortgage			$	$ 1,021,958			$ 76,198	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Oxford Coverage Insurance		X					22,283				6
7												7
8												8
9	TOTAL Facility Related						$	$ 1,044,241			$ 76,198	9
	B. Non-Facility Related*											
10	Supplemental Schedule											10
11	INTEREST EXPENSE										1,186	11
12	INTEREST INCOME										(6,547)	12
13	Hickory Health Care Assoc			Interest Income							(824)	13
14	TOTAL Non-Facility Related						$	$			$ (6,185)	14
15	TOTALS (line 9+line14)						$	$ 1,044,241			$ 70,013	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	91,292	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	90,982	2
3. Under or (over) accrual (line 2 minus line 1).	$	(310)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	93,711	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	2,160	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	95,561	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	79,796	8
	1996	85,314	9
	1997	85,525	10
	1998	88,633	11
	1999	90,982	12

R.E. Taxes Accrual 2000:
90,982 x 1.05 = 95,531
APPEAL COSTS PERTAINING TO THE 1999 ASSESSED VALUATION COMPLAINT
FILED IN COOK COUNTY, ILLINOIS.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:
1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,200 B. General Construction Type: Exterior BRICK Frame BRICK Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 1,275
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	16,200	1990	$ 74,000	1
2					2
3	TOTALS	16,200		$ 74,000	3

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		1990	1961	$ 1,115,000	$ 35,397	20	$ 55,750	$ 20,353	$ 480,523	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	22,801	724	20	1,140	416	12,154	9
10	Various			1988	50,319	1,597	20	2,516	919	25,602	10
11	Various			1989	7,409	204	20	370	166	3,290	11
12	Various			1990	38,661	1,258	20	1,934	676	17,505	12
13	Various			1991	6,422	204	20	321	117	2,627	13
14	Various			1993	30,582	797	20	1,530	733	10,163	14
15	Various			1994	13,592	348	20	680	332	4,105	15
16	Various			1995	102,781	2,505	20	5,139	2,634	26,813	16
17	CIRCUITS			1996	2,205	57	20	110	53	477	17
18	HAND RAILS			1996	1,950	50	20	98	48	425	18
19	ROOF			1996	48,500	1,244	20	2,425	1,181	11,721	19
20	CIRCUITS			1996	22,500	577	20	1,125	548	5,438	20
21	DRYWALL			1996	5,600	144	20	280	136	1,237	21
22	SINKS AND PIPING			1996	3,245	83	20	162	79	702	22
23	WINDOW TREATMENT			1996	1,839	47	20	92	45	376	23
24											24
25	PAGE 12-1 REP TOTALS				3,408	1,355		110	(1,245)	932	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				26,069			1,304	1,304	1,995	34
35	PAGE 12A TOTALS				159,223	3,034		7,962	4,928	28,489	35
36	TOTAL (lines 4 thru 35)				$ 1,662,106	$ 49,625		$ 83,048	$ 33,423	$ 634,574	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ELECTRICAL CONDUIT			1996	1,785	46	20	89	43	423	9
10	DECORATING			1996	19,789		20	989	989	3,956	10
11	REFURBISH ROOMS-A/W			1996	30,670	786	20	1,534	748	7,414	11
12	DRYWALL			1996	1,527	39	20	76	37	374	12
13	AWNINGS			1996		67	20		(67)		13
14	DECORATING			1997	5,492		20	275	275	825	14
15	AWNINGS-AUD ADJ			1997	2,600		20	130	130	628	15
16	GARAGE			1997	6,176	158	20	309	151	1,004	16
17	ALARM SYSTEM			1997	1,799		20	90	90	308	17
18	PARKING LOT			1997	732		20	37	37	133	18
19	GUTTER			1997	500	13	20	25	12	79	19
20	WINDOWS			1997	24,950	640	20	1,248	608	4,160	20
21	AWNING			1997	9,000	231	20	450	219	1,800	21
22	PAVING & SHOVELING			1997	3,500	90	20	175	85	642	22
23	FLOORING			1998	1,728		20	86	86	244	23
24	HEATER			1998	3,134		20	157	157	458	24
25	FLOOR TILING			1998	1,281		20	64	64	187	25
26	CARPET			1998	503		20	25	25	71	26
27	DRAIN PIPE			1998	2,700		20	135	135	326	27
28	GREASE TRAP			1998	767		20	38	38	89	28
29	AWNINGS			1998	675		20	34	34	77	29
30	GREASE TRAP			1998	575		20	29	29	60	30
31	MASONRY			1998	3,700	95	20	185	90	416	31
32	DIFFUSER			1998	540		20	27	27	59	32
33	REPLACE BRICK			1998	3,200	82	20	160	78	360	33
34	MASONRY			1998	30,700	787	20	1,535	748	4,221	34
35	PIPING			1998	1,200		20	60	60	175	35
36	TOTAL (lines 4 thru 35)				$ 159,223	$ 3,034		$ 7,962	$ 4,928	$ 28,489	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WATER HEATER			1998	1,062		20	53	53	159	9
10	CARPET			1998	1,757		20	88	88	257	10
11	ALUMI-COAT			1999	1,863		20	93	93	116	11
12	CABINETS/COUNTERS			1999	3,303		20	165	165	303	12
13	ALUMI-COAT			1999	2,421		20	121	121	151	13
14	PATIO			1999	1,050		20	53	53	66	14
15	DUMPSTER			1999	1,920		20	96	96	120	15
16	PLUMBING			1999	547		20	27	27	36	16
17	REFURBISH ROOMS			1999	1,725		20	86	86	151	17
18	ELECTRICAL REPAIRS			1999	1,100		20	55	55	105	18
19	SEWER PIPE			1999	650		20	33	33	61	19
20	SEWER			1999	4,300		20	215	215	251	20
21	FIRE ALARM REPAIR			2000	569		20	28	28	28	21
22	GAS LINE REPAIR			2000	1,070		20	54	54	54	22
23	GAS LINE REPAIR			2000	1,170		20	59	59	59	23
24	GLASS/DOOR REPAIR			2000	1,562		20	78	78	78	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 26,069	$		$ 1,304	$ 1,304	$ 1,995	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATED FROM STAYCARE			1992	2,100	47	20	105	58	927	9
10	ALLOCATED FROM STAYCARE			2000	1,308	1,308	20	5	(1,303)	5	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 3,408	$ 1,355		$ 110	$ (1,245)	$ 932	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 109,742	$ 10,093	$ 10,977	$ 884		$ 39,661	37
38	Current Year Purchases	3,676		184	184		184	38
39	Fully Depreciated Assets	197,306					197,306	39
40								40
41	TOTALS	$ 310,724	$ 10,093	$ 11,161	$ 1,068		$ 237,151	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,046,830	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 59,718	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 94,209	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 34,491	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 871,725	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

HICKORY NURSING PAVILION, INC.
0032029
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Hickory Nursing Pavilion	101,692	10,093	10,172	79	34,537
Staycare Management	8,050		805	805	5,124
Hickory Health Care Associates					
TOTALS	109,742	10,093	10,977	884	39,661
LINE 29: CURRENT YEAR					
Hickory Nursing Pavilion	3,676		184	184	184
Staycare Management					
Hickory Health Care Associates					
TOTALS	3,676		184	184	184
LINE 30: FULLY DEPRECIATED					
Hickory Nursing Pavilion	86,306				86,306
Staycare Management					
Hickory Health Care Associates	111,000				111,000
TOTALS	197,306				197,306
TOTALS (Should Tie to Totals on Page 13)					
Hickory Nursing Pavilion	191,674	10,093	10,356	263	121,027
Staycare Management	8,050		805	805	5,124
Hickory Health Care Associates	111,000				111,000
TOTALS	310,724	10,093	11,161	1,068	237,151

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		74		$			3
4	Additions	ALLOCATED FROM STAYCARE			5,168			4
5								5
6								6
7	TOTAL		74		$ 5,168 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 2,423 Description: ALLOCATED FROM STAYCARE
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 33,761	$		$ 33,761	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			515			515	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			31,096			31,096	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				32,067		32,067	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**						11,067		11,067	13
14	TOTAL			$ 0		$ 65,372	$ 43,134		$ 108,506	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Complex Medical Equip	1,140
2	Laboratory Costs	9,927
3		
4		
5		
6		
7		
8		
9		
10		
		11,067

	Outside Therapies (Column 5 - Other)	Amount
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 230,275	$ 257,409	1
2	Cash-Patient Deposits	22,247	22,247	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	491,692	703,370	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,434	33,434	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		14,039	8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 777,648	$ 1,030,499	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		74,000	13
14	Buildings, at Historical Cost		1,115,000	14
15	Leasehold Improvements, at Historical Cos	471,614	471,614	15
16	Equipment, at Historical Cost	170,129	281,129	16
17	Accumulated Depreciation (book methods)	(241,091)	(710,496)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(2,550)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 400,652	$ 1,228,697	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,178,300	$ 2,259,196	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 50,505	$ 50,505	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,277	22,277	28
29	Short-Term Notes Payable	22,283	22,283	29
30	Accrued Salaries Payable	14,194	14,194	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,529	1,529	31
32	Accrued Real Estate Taxes(Sch.IX-B)	93,711	93,711	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,980	3,980	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	231,377	218,632	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 439,856	$ 427,111	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,021,958	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,021,958	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 439,856	$ 1,449,069	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 738,444	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,178,300	$ #REF!	48

*(See instructions.)

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount

OTHER CURRENT LIABILITIES:	Amount	Amount
SECURITY DEP/DUE TO PTSHP	218,977	218,977
DEFERRED INCOME	12,400	12,400
LOAN FEES		(12,745)
	231,377	218,632

OTHER NON CURRENT ASSETS:

Construction In Progress
Utility Deposit
Loan Costs

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 623,900	1
2	Restatements (describe):		2
3	**Schedule attached**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 623,900	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	262,544	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(148,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 114,544	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 738,444	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	HICKORY NURSING PAVILION, INC #	0032029	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		623,900
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		623,900
Equity(Deficit) from Page 17 Col 1		738,444
Related Party		
Equity(Deficit)	6510.04	
Income	65172.6	
		71,683
Combined Equity - End of Year		810,127

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,173,485	1
2	Discounts and Allowances for all Levels	(37,360)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,136,125	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	262,200	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 262,200	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,857	19
20	Radiology and X-Ray		20
21	Other Medical Services	54,150	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 74,007	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,547	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,547	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,478,879	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	460,297	31
32	Health Care	791,577	32
33	General Administration	517,776	33
	B. Capital Expense		
34	Ownership	297,553	34
	C. Ancillary Expense		
35	Special Cost Centers	108,506	35
36	Provider Participation Fee	40,626	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,216,335	40
41	**Income before Income Taxes (line 30 minus line 40)****	262,544	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 262,544	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HICKORY NURSING PAVILION, I # 0032029 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,484	1,580	$ 34,615	$ 21.91	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,965	2,244	45,588	20.32	3
4	Licensed Practical Nurses	14,494	15,373	253,572	16.49	4
5	Nurse Aides & Orderlies	29,244	30,360	261,490	8.61	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,846	4,126	34,186	8.29	8
9	Activity Director	2,347	2,531	18,296	7.23	9
10	Activity Assistants	1,729	1,769	9,865	5.58	10
11	Social Service Workers	2,431	2,775	27,810	10.02	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,128	26,806	12.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,857	11,457	72,941	6.37	15
16	Dishwashers					16
17	Maintenance Workers	2,804	2,892	24,282	8.40	17
18	Housekeepers	9,639	9,899	47,135	4.76	18
19	Laundry	4,038	4,342	35,424	8.16	19
20	Administrator	2,100	2,212	57,661	26.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	643	671	9,468	14.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,489	4,833	68,059	14.08	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	94,094	99,192	$ 1,027,198 *	$ 10.36	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	128	$ 5,109	1-3	35
36	Medical Director	MONTHLY	1,800	9-3	36
37	Medical Records Consultant	MONTHLY	2,024	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	2,968	10-3	39
40	Physical Therapy Consultant	48	1,692	10A-3	40
41	Occupational Therapy Consultant	271	9,474	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	72	10A-3	43
44	Activity Consultant	67	1,680	11-3	44
45	Social Service Consultant	38	958	12-3	45
46	Other(specify)				46
47	Psycho-Social Rehab Csltnt	19	860	12-3	47
48					48
49	TOTAL (lines 35 - 48)	573	$ 26,637		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	N/A	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$ 0		53

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Doreen Murphy	Administrator	0	$ 57,661
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 57,661

B. Administrative - Other

Description	Amount
STAYCARE MGMNT FEES	$ 145,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 145,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	ACCOUNTING	$ 24,330
SACHNOFF AND WEAVER	LEGAL	1,500
PERSONNEL PLANNERS	UNEMPLOYMENT CSLTNT	528
FINKEL, MARTWICK, COLSON	REAL EST. TAX APPEAL	2,160
SAS ARCHITECTS & PLANNERS	ARCHITECTURAL SERV.	1,858
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 30,376

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 12,744
Unemployment Compensation Insurance	8,891
FICA Taxes	77,932
Employee Health Insurance	36,669
Employee Meals	21,653
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	180
Union Pension	6,889
401k Contribution	1,060
TOTAL (agree to Schedule V, line 22, col.8)	$ 166,018

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,723
Health Care Worker Background Check	3,300
(Indicate # of checks performed 165)	
Licenses, Permits, Fees	1,102
Promotional Avertising	962
Dues and Subscriptions	3,042
Yellow Pages Advertising	7,603
Staycare allocation	180
Less: Public Relations Expense	( )
Non-allowable advertising	(962)
Yellow page advertising	(7,603)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,347

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Staycare Allocation	202
Seminar Expense	1,425
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,627

**See instructions.

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HICKORY NURSING PAVILION, INC. # 0032029 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $3,034**

(3) Did the nursing home make political contributions or payments to a politica action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,613** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **40,626**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **NA**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **21,653** Has any meal income been offset against related costs? **NA** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **NA**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? NA
Indicate the amount of income earned from providing such transportation during this reporting period. $ **NA**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw